BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Doron Blumenfeld, M.D. Physician's and Surgeon's Certificate No. A 45201 Respondent.	Case No. 800-2020-073621

DECISION

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

his Decision shall become effective at 5:00 p.m. on December 15, 2022.

IT IS SO ORDERED December 8, 2022.

MEDICAL BOARD OF CALIFORNIA

William Prasifka
Executive Director

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
MARSHA BARR-FERNANDEZ
Deputy Attorney General
State Bar No. 200896
300 South Spring Street, Suite 1702
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DORON BLUMENFELD, M.D.** **5007 Gerald Ave.** **Encino, CA 91436** **Physician's and Surgeon's Certificate No. A45201,** Respondent.	Case No. 800-2020-073621 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Marsha Barr-Fernandez, Deputy Attorney General.

2. DORON BLUMENFELD, M.D. (Respondent) is represented in this proceeding by attorney Thomas F. McAndrews, Esq., whose address is: 1230 Rosecrans Ave., Suite 450, Manhattan Beach, CA 90266.

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3. On or about August 15, 1988, the Board issued Physician's and Surgeon's Certificate No. A 45201 to DORON BLUMENFELD, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2020-073621 and will expire on January 31, 2024, unless renewed.

JURISDICTION

4. Accusation No. 800-2020-073621 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on August 30, 2022. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2020-073621 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2020-073621. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2020-073621, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

10. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

CONTINGENCY

11. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

12. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Surrender of License and Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 45201, issued to Respondent DORON BLUMENFELD, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline

against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2020-073621 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $22,526.00 (estimated costs) prior to issuance of a new or reinstated license.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2020-073621 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney Thomas F. McAndrews, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 11/29/2022

DORON BLUMENFELD, M.D.
Respondent

I have read and fully discussed with Respondent DORON BLUMENFELD, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: November 30, 2022

THOMAS F. MCANDREWS, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: November 30, 2022

Respectfully submitted,

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

Marsha E. Barr-Fernandez

MARSHA BARR-FERNANDEZ
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2020-073621

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 800-2020-073621
Doron Blumenfeld, M.D. **5007 Gerald Ave.** **Encino, CA 91436-1103** **Physician's and Surgeon's Certificate No. A 45201,** Respondent.	**ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about August 15, 1988, the Board issued Physician's and Surgeon's Certificate Number A 45201 to Doron Blumenfeld, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2024, unless renewed. Respondent's Physician's and Surgeon's Certificate has been in retired status since March 1, 2022, he is not permitted to practice medicine in California while his medical license is in retired status.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2220 of the Code states:

> Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:
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> (a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.
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> (b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.
>
> (c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon.

5. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
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> (1) Have his or her license revoked upon order of the board.
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> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
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> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
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> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

6. Section 2228.1 of the Code states.

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board and the Podiatric Medical Board of California shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information internet web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction directly involving harm to patient health.

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information internet web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

STATUTORY PROVISIONS

7. Section 2234 of the Code, states:

The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the

licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

8. Section 2266 of the Code states:

The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

9. Section 726 of the Code states:

(a) The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under this or under any initiative act referred to in this division.

(b) This section shall not apply to consensual sexual contact between a licensee and his or her spouse or person in an equivalent domestic relationship when that licensee provides medical treatment, to his or her spouse or person in an equivalent domestic relationship.

COST RECOVERY

10. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested

pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

FACTUAL ALLEGATIONS

Patient 1:

11. Patient 1,[1] a then 22-year-old female, presented to the emergency department of UCLA-Santa Monica Medical Center on or about September 3, 2015, with complaints of severe abdominal/pelvic pain and mild vaginal spotting. Patient 1 advised her caregivers that she had newly arrived to the United States and spoke limited English. Patient 1 was examined in the emergency department and an assessment of pelvic inflammatory disease, presumed complicated with possible bilateral tubo-ovarian abscesses, was rendered. Patient 1 also had a positive urine PCR test for Chlamydia. Patient 1 was admitted to the hospital for further care, including a gynecological consultation/examination.

[1] The patients are identified in this Accusation by number for privacy purposes.

12. On or about September 3, 2015, Patient 1 and her two girlfriends were sleeping in her patient room at UCLA-Santa Monica Medical Center. Respondent walked into Patient 1's room, slapped one of her friends on her buttocks and stated, "wake-up, this isn't a hotel." Respondent was accompanied by a male nurse. Neither the nurse, nor Respondent, introduced themselves to Patient 1. Respondent then asked Patient 1 to sit on a urine specimen cup so he could better conduct an examination of her genitals. Patient 1's friends were not asked to leave the room. Respondent conducted the gynecological examination without first asking for Patient 1's consent to do so, without asking Patient 1 if she consented to a male nurse, and if she consented to have her friends in the room during the examination. Patient 1 felt exposed and embarrassed; she was also in severe pain. Following the procedure, Respondent elected to remove Patient 1's intrauterine device (IUD). During the IUD removal procedure, Patient 1 experienced extreme pain. She was crying and scared because she did not understand what was going on. Respondent did not explain to Patient 1 what he was about to do, or if he did, Patient 1 did not understand because she did not speak English well. Throughout the patient encounter, Patient 1 was never offered an interpreter. Patient 1 began to scream, tried to push herself away from Respondent, and was kicking and "hammering the bed" with her hands. She screamed for Respondent to, "stop, please stop, please stop, it hurts." Respondent continued with the procedure and forcibly removed the IUD. According to Patient 1, she tried to close her legs to keep Respondent away, but Respondent firmly held her legs open. Patient 1 also believes that Respondent used his hands to remove her IUD. However, there is no procedure note that details Respondent's removal of the IUD, or how the patient tolerated the procedure.

13. Following the IUD removal, Patient 1 flung herself off the bed. She reported feeling violated, and humiliated. Respondent told her to, "stop being so dramatic," and left the room. Patient 1 felt belittled. Patient 1 was left crying on her patient room floor. Her friends were also horrified and crying. One friend stated that she felt as if she had watched someone being raped and could do nothing.

14. Later that night, Patient 1 told hospital staff that she did not want to receive further treatment from Respondent, because she was terrified of him. Patient 1 spoke with her night

nurse, a nursing supervisor, and uniformed officers and reported what had transpired that morning.

15. Respondent documented in Patient 1's chart, "remove IUD and send for cultures." There is no documentation of an informed consent for the gynecological examination or IUD removal. There is no documentation that a chaperone was present. Respondent did not document if he offered Patient 1 a language translator. The "Procedure Note" area is left blank.

16. The next morning, on or about September 4, 2015, Respondent walked into Patient 1's hospital room and awakened her. Patient 1 froze. A nurse came and escorted Respondent out of Patient 1's room and admonished him that he knew he was not to see Patient 1.

17. Patient 1 reports that she had no discussion with Respondent regarding her medical history. Respondent did not advise her of the results of the tests that were conducted the prior night in the emergency department. Nevertheless, Respondent documented Patient 1's medical history as, "indicated sexually active with an IUD ParaGard, unprotected sex with multiple partners." The plan indicated: "IUD removal, to send for culture and sensitivity." Respondent also noted that Patient 1 was a non-smoker. Throughout her chart it is noted that Patient 1 "admits to active tobacco use."

18. On or about February 20 2019, Patient 1 wrote a negative "Yelp" review about Respondent. A photo of Patient 1's face is fully visible. Her full name is identifiable.

19. Respondent replied to Patient 1's negative "Yelp" review on or about February 26, 2019. He acknowledges that he was her treating physician at UCLA-Santa Monica Hospital. He disclosed her symptoms and that she was admitted for severe pelvic pain and an infection, due to a complication of an IUD. Respondent disclosed Patient 1's personal confidential contraceptive choice, her treatment plan, including the use of antibiotics, the medical concern for sepsis, and the need for the IUD removal. All of this information appeared on the Yelp website.

20. Respondent disclosed Patient 1's personal health information, which was and is protected under HIPAA (Health Insurance Portability and Accountability Act of 1996).

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Patient 2:

21. Patient 2, a then 40-year-old female, was under the care of Respondent's partner, Dr. P.S., for treatment of endometriosis. She was managed on Orilissa, an oral medication. To better assist in the management of the endometriosis pain, a Mirena IUD was inserted on or about July 17, 2019.

22. On or about August 8, 2019, Patient 2 telephoned Dr. P.S. to inform her that she was experiencing heavy bleeding and she believed that the IUD was expelling from her cervix. On or about August 10, 2019, Dr. P.S. called Patient 2 and advised her to come in to the office for an examination and possible removal of the IUD. An appointment was made for Monday, August 12, 2019 at 10:30 a.m. Patient 2 believed that she would be seeing Dr. P.S. on August 12th.

23. On or about August 12, 2019, Patient 2 arrived for her appointment at Women's Healthcare Associates of Santa Monica. She was placed in a room by a nurse, given a gown and drape, and asked to disrobe.

24. Respondent entered Patient 2's examination room. He did not introduce himself and Patient 2 had never met Respondent at her prior visits to Women's Healthcare Associates of Santa Monica. Patient 2 was not offered a chaperone. Patient 2 recalls her legs in stirrups and Respondent asking her to slide her bottom down. Those were the only words Respondent spoke to Patient 2 prior to the transvaginal sonogram, [2] pelvic examination, and IUD removal procedure.

25. Respondent inserted a transvaginal sonogram transducer and moved it in an aggressive and forceful manner, according to Patient 2. Each time the transducer struck the expelling IUD, it caused her severe pain, leaving her sobbing. The results of the transvaginal sonogram indicated that the IUD was in the cervical canal and revealed that Patient 2 had bilateral ovarian cysts. Respondent did not obtain an informed consent from Patient 2 for a transvaginal sonogram.

26. After Respondent concluded the transvaginal sonogram he inserted a speculum into Patient 2's vagina. He repeatedly removed and reinserted the speculum several times, causing

[2] Transvaginal sonogram or ultrasound is an internal scan of the female reproductive organs. It involves inserting a probe or transducer into the vagina to produce detailed images of the organs of the female pelvic region.

Patient 2 additional discomfort and pain. Patient 2 asked Respondent to stop, but he did not. Respondent did not address Patient 2. Once he had the speculum in place, Respondent opened the treatment room door, leaving Patient 2 exposed to anyone walking in the hallway. Respondent yelled out for a nurse to assist him, because he encountered significant bleeding. Respondent's comment frightened Patient 2. Respondent did not obtain an informed consent from Patient 2 for the speculum examination.

27. Respondent returned to Patient 2, and using the same gloved hand that he used to perform the transvaginal sonogram and open the examination room door, inserted his hand into Patient 2's vagina and pulled out the IUD. Patient 2 saw that Respondent discarded the bloody IUD in the waste bin. Respondent did not obtain an informed consent from Patient 2 for an IUD removal procedure.

28. Patient 2 was sobbing from the pain. Respondent got up and noticed that Patient 2 was crying and inquired why. Patient 2 stated, "all of this; all of it." Respondent told Patient 2 to, "pull herself together and meet him in his office." Patient 2 felt humiliated, dehumanized, and horrified by the experience.

29. Later that day, Patient 2 received an online request from Women's Healthcare Associates of Santa Monica to review her appointment. Patient 2 gave an honest review and commented about how horrible the experience was for her. She received a call from Respondent the following day, on or about August 13, 2019. Respondent stated that he would send Patient 2 a letter to better account for his conduct, but indicated that he had been experiencing back pain and made an emergency appointment for himself.

30. Patient 2 thought that she would be receiving an email response from Respondent. Having not heard from him, she posted a negative review on Yelp on or about August 16, 2019. On or about August 20, 2019, Patient 2 received letters of apology from Respondent and Dr. P.S.

31. In her Yelp review a photo of Patient 2's face is fully visible. Her first name is identifiable, followed by the first initial of her last name.

32. Respondent responded to Patient 2's negative Yelp review on or about October 2, 2019. He reported that he had been in severe pain that day and that it had impacted his behavior.

He added that he set up an appointment with his spine specialist for that day. Respondent went on to post a copy of the apology letter he sent to Patient 2, which included information regarding her private medical history, the dislodged Mirena IUD, her treatment, including inserting the speculum two to three times to visualize her cervix. Respondent discussed Patient 2's bilateral ovarian cysts, the IUD removal and her follow up plan. All of this information appeared on the Yelp website.

33. Respondent disclosed Patient 2's personal health information, which was and is protected under HIPAA.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

34. Respondent Doron Blumenfeld, M.D. is subject to disciplinary action under section 2234, subdivision (b) of the Code in that his care and treatment of Patients 1 and 2 was grossly negligent. The circumstances are as follows:

35. Respondent is an obstetrician and gynecologist. His California Physician's and Surgeon's Certificate is currently in retired status. Prior thereto, he was in private practice in Santa Monica with Women's Healthcare Associates of Santa Monica.

36. The facts and allegations set forth in paragraphs 11 through 33, above, are realleged herein as if fully set forth.

Lack of Informed Consent

37. Prior to performing any gynecologic examination, including a transvaginal sonogram, a pelvic examination, and IUD removal procedure, an informed consent discussion should be conducted between the OB/GYN and the patient. That discussion should be documented.

38. According to the American College of Obstetricians and Gynecologists Committee Opinion 819, Committee on Ethics, entitled *Informed Consent and Shared Decision Making in Obstetrics and Gynecology* (ACOG-819): "the goal of the 'informed consent process' is to provide patients with information that is necessary and relevant to their decision making (including the risks and benefits of accepting or declining recommended treatment) and to assist the patient in identifying the best course of action for their medical care. Shared decision making

should be patient focused and involves the discussion of the benefits, risks of the available treatment, as well as alternatives. The informed consent conversation should be documented in the medical record."

39. According to ACOG-819, the OB/GYN should provide adequate, accurate and understandable information and requires that the patient can understand and reason through the information. The patient should be free to ask questions and to make an intentional and voluntary choice, which may include refusal of care or treatment.

40. ACOG-819 further provides that: "to meet the requirements of the disclosure of accurate and comprehensive information, the counseling OG/GYN should engage in effective patient centered and culturally responsive communication. The patient should also have adequate understanding of the language used by their OB/GYN during the informed consent process. To help avoid miscommunication related to language differences, a professional medical interpreter should be made available in person, by phone, or through video remote technology to assist with the informed consent."

41. At any time during the doctor-patient relationship, the patient has the right to withdraw consent to be seen and/or receive treatment from the physician. Respect for patient autonomy is one of the pillars of medical ethics. Self-determination and informed consent without fear or coercion is of paramount importance.

Patient 1:

42. Respondent failed to obtain and document an informed consent from Patient 1 for a pelvic examination and the IUD removal procedure. There was no discussion of risks, benefits, or alternatives to the examination or procedure. Patient 1 reported that English was her second language and she only understood simple English, as she was a newcomer to the United States. Accordingly, Respondent should have offered Patient 1 an interpreter. Alternatively, Respondent should have ensured that Patient 1 understood the proposed procedure in simple, layperson's terms. During the IUD removal procedure Patient 1 repeatedly asked Respondent to stop. Her strong pleas, crying, and physical resistance were ignored by Respondent.

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43. Respondent's failure to obtain and document an informed consent from Patient 1 for the pelvic examination and the IUD removal procedure is an extreme departure from the standard of care.

Patient 2:

44. Patient 2 states that she was never provided an informed consent to any of the procedures performed by Respondent on or about August 12, 2019. Respondent did not document an informed consent in Patient 2's medical chart. Respondent did not obtain an informed consent from Patient 2 for the transvaginal sonogram, the speculum assisted pelvic examination, or the IUD removal procedure. When Patient 2 asked Respondent to stop inserting the speculum into her vagina, he ignored her.

45. Respondent's failure to obtain and document an informed consent from Patient 2 for the transvaginal sonogram, the speculum assisted pelvic examination, and the IUD removal procedure, is an extreme departure from the standard of care.

HIPAA Violation

46. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a national standard that protects sensitive patient health information from being disclosed without the patient's consent or knowledge. Protected health information (PHI) is considered to be individually identifiable information relating to the past, present, or future health status of an individual that is created, collected, transmitted, or maintained by a HIPAA-covered entity in relation to the provision of healthcare payment for healthcare services, or use in healthcare operations. Health information such as diagnoses, treatment information, medical test results, and prescription information are considered protected health information under HIPAA.

47. When responding to a patient's online comments or reviews, the health care professional should always maintain his or her professionalism and never disclose a patient's protected health information.

Patient 1:

48. Respondent's disclosure of Patient 1's protected health information in an online Yelp response is a violation of HIPAA and is an extreme departure from the standard of care.

Patient 2:

49. Respondent's disclosure of Patient 2's protected health information in an online Yelp response is a violation of HIPAA and is an extreme departure from the standard of care.

Sexual Misconduct

50. Sexual misconduct by a physician is considered an abuse of professional power and a violation of patient trust. According to the American College of Obstetricians and Gynecologist Committee Opinion 796, Committee on Ethics on Sexual Misconduct (ACOG-796): "physical examinations should be explained appropriately, undertaken only with the patient's consent, and performed with the minimal amount of physical contact required to obtain data for diagnosis and treatment. Draping of the patient should occur to minimize exposure. A chaperone is recommended for all breast and pelvic examinations. Appropriate explanation should accompany all examinations and procedures." ACOG-796 reiterates that examination of the breasts or genitals without appropriate consent from a patient or surrogate decision maker qualifies as sexual misconduct under categories of sexual impropriety and sexual violation.

Patient 1:

51. Respondent failed to explain to Patient 1 that he was going to conduct a pelvic examination on her and obtain her informed consent. He then failed to explain the IUD removal procedure and obtain Patient 1's consent. Respondent did not document an informed consent in Patient 1's medical record. Patient 1 was unaware of what Respondent was doing to her and felt violated, humiliated, and traumatized by the procedures. Patient 1 spoke only limited English with little understanding of medical terminology. She was not provided a medical translator to obtain her informed consent. During the IUD removal procedure, Patient 1 repeatedly asked Respondent to terminate the procedure. Nevertheless, Respondent forcibly continued the procedure against Patient 1's wishes.

52. Conducting a procedure without an informed consent and against the express wishes of the patient constitutes sexual misconduct and is an extreme departure from the standard of care. Forcibly removing an IUD from a patient against her wishes constitutes sexual misconduct and is an extreme departure from the standard of care.

Inappropriate IUD Removal

53. Prior to performing an IUD removal procedure, the OB/GYN should introduce themselves to their patient and provide a full informed consent. The physician should obtain a medical history from the patient. The patient should also be offered a chaperone. The patient should be appropriately draped to protect their privacy. When performing the procedure, the OB/GYN should explain the steps taking place to prevent any misunderstandings.

54. In the situation of a displaced IUD, it is customary and common practice to perform a speculum pelvic examination before a transvaginal sonogram. The cervix and surrounding tissue, as well as the partially displaced IUD should be visualized (if possible). Insertion of the ultrasound transducer prior to visual inspection of the cervix and vaginal tissue may cause additional tissue damage, trauma, or harm since a displaced/partially expulsed IUD may be moved or hit by the ultrasound transducer.

55. It is common practice that when removing the IUD, the strings are grasped by a medical instrument. Gloves that are worn for a pelvic examination should be discarded and replaced once the exam is terminated. Fresh gloves should be used for the next procedure. A detailed procedure note of the IUD removal should be included in the medical record.

Patient 2:

56. Respondent did not introduce himself when he first encountered Patient 2. He did not obtain an informed consent from Patient 2 for any of the examinations or procedures he conducted. He did not obtain a medical history from Patient 2. He never offered Patient 2 a chaperone. Respondent left Patient 2 exposed in stirrups when he opened the examination room door and called for a nurse.

57. Respondent inappropriately performed the transvaginal sonogram prior to performing the speculum pelvic examination on Patient 2 and the ultrasound transducer exacerbated Patient 2's pain. Respondent did not change gloves between examinations, procedures, or after he opened the examination room door. Respondent did not advise Patient 2 of the medical steps he was about to take so she would understand what was about to occur during her examinations and

treatment. This caused Patient 2 to be scared, upset, and feel dehumanized. Respondent did not document a procedure note.

58. Respondent's failure to perform and document an appropriate IUD removal procedure is an extreme departure from the standard of care.

Provider Impairment

59. Provider impairment includes issues relating to mental and physical impairment. A physician's personal health problems, including injury, aging, burnout, circadian rhythm disruption, substance use disorders, and other conditions can detract from a physician's performance and can interfere with a physician's ability to safely engage in patient care.

Patient 2:

60. Respondent admitted to Patient 2, verbally and in writing, that he was in severe pain during her visit on or about August 12, 2019, and that his back pain had an impact on his behavior. Respondent admitted that his behavior was wrong. He acknowledged that he did not introduce himself to Patient 2, he did not read her file, and he was rushed during her visit. Respondent further acknowledged that he did not follow up with Patient 2's response when he asked her why she was crying. Respondent notes in his letter that his pain was so severe he "set up an emergency visit with his spine specialist that day."

61. Respondent's self-report of physical impairment of severe back pain on or about August 12, 2019, which directly impacted his behavior and resulted in harm to Patient 2, is an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

62. Respondent Doron Blumenfeld, M.D. is subject to disciplinary action under section 2234, subdivision (c) of the Code in that he provided negligent care and treatment to Patients 1 and 2. The circumstances are as follows:

63. The facts and allegations set forth in the First Cause for Discipline are incorporated by reference as if fully set forth.

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64. Each of the alleged acts of gross negligence set forth in the First Cause for Discipline, above, is also a negligent act.

THIRD CAUSE FOR DISCIPLINE

(Sexual Misconduct)

65. Respondent Doron Blumenfeld, M.D. is subject to disciplinary action under section 726 of the Code in that he committed sexual misconduct during his care and treatment of Patient 1 and Patient 2. The circumstances are as follows:

66. The facts and allegations set forth in the First Cause for Discipline are incorporated by reference as if fully set forth.

67. The facts and allegations set forth in paragraphs 11 through 33, above, are realleged herein as if fully set forth.

Patient 1:

68. Respondent failed to explain to Patient 1 that he was going to conduct a pelvic examination on her and obtain her informed consent. He then failed to explain the IUD removal procedure and obtain Patient 1's consent. Respondent did not document an informed consent in Patient 1's medical record. Patient 1 was unaware of what Respondent was doing to her and she felt violated, humiliated and traumatized by the procedures. Patient 1 spoke only limited English with little understanding of medical terminology. She was not provided a medical translator to obtain her informed consent. During the IUD removal procedure Patient 1 repeatedly asked Respondent to terminate the procedure. Nevertheless, Respondent forcibly continued the procedure against Patient 1's wishes. Respondent also failed to ensure Patient 1's privacy; he conducted a gynecological examination and procedure in front of her friends.

69. Conducting a procedure without obtaining an informed consent and against the express wishes of the patient constitutes sexual misconduct. Forcibly removing an IUD from a patient against her wishes constitutes sexual misconduct.

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Patient 2:

70. Respondent performed a transvaginal sonogram on Patient 2 followed by a speculum assisted pelvic examination without an informed consent. Respondent then performed an IUD removal procedure on Patient 2 without an informed consent. This constitutes sexual misconduct.

71. Respondent continued with a speculum insertion on Patient 2, during which she repeatedly requested that the procedure be terminated. Respondent continued with the procedure against Patient 2's wishes. This constitutes sexual misconduct.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

72. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 45201 to disciplinary action under sections 2227, 2234, 2234, subdivision (a), and 2228.1 of the Code, in that he engaged in conduct which breached the rules or ethical code of the medical profession or which was unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. Respondent's unprofessional conduct resulted in harm to Patient 1 and Patient 2. The circumstances are as follows:

73. The facts and allegations set forth in the First and Third Causes for Discipline are incorporated by reference as if fully set forth.

74. The facts and allegations set forth in paragraphs 11 through 33, above, are realleged herein as if fully set forth.

75. The American Board of Internal Medicine (AMIB) established Project Professionalism, which sought to define the components of medical professionalism, including altruism, accountability, excellence, duty, honor/integrity, and respect.

Patient 1:

76. Respondent demonstrated unprofessional conduct in his care and treatment of Patient 1 by slapping her friend on her buttocks to wake up Patient 1 and her friends on September 3, 2015, in failing to introduce himself to Patient 1, and in failing to demonstrate empathy for Patient 1 when she was emotional and crying during the IUD removal procedure. Respondent was also dismissive of Patient 1 in telling her "not to be dramatic," following the IUD removal

procedure. Respondent also did not ask Patient 1's friends to leave her room before he performed a private gynecological examination and procedure on Patient 1. Respondent's unprofessional conduct resulted in harm to Patient 1.

Patient 2:

77. Respondent demonstrated unprofessional conduct in his care and treatment of Patient 2 on or about August 12, 2019, by failing to introduce himself to her, by rushing through her examinations and procedure, by leaving her exposed and not ensuring her privacy, and in failing to demonstrate empathy for Patient 2 when she was emotional and crying during the speculum examination and IUD removal procedure. Respondent was also dismissive of Patient 2 in telling her to "pull herself together" following her IUD removal procedure. Respondent's unprofessional conduct resulted in harm to Patient 2.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

78. Respondent Doron Blumenfeld, M.D. is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate medical records during his care of Patients 1 and 2. The circumstances are as follows:

79. The facts and allegations set forth in the First Cause for Discipline are incorporated by reference as if fully set forth.

80. The facts and allegations set forth in paragraphs 11 through 33, above, are realleged herein as if fully set forth.

Patient 1:

81. The standard of care calls for a physician to maintain adequate and accurate medical records for his or her patients.

82. Respondent did not perform a comprehensive history on Patient 1, including a medical and gynecological history. There are inconsistencies with Respondent's documentation of Patient 1's sexual history and use of tobacco. Respondent did not chart an informed consent discussion for the pelvic examination and IUD removal procedure he performed on Patient 1.

Respondent did not document a procedure note following the IUD removal procedure. He did not document how Patient 1 tolerated the procedure.

Patient 2:

83. Respondent did not document a medical history for Patient 2. He did not chart an informed consent discussion for the transvaginal ultrasound, speculum pelvic examination, or IUD removal procedure. Respondent did not chart a procedure note for the IUD removal procedure. He did not document how Patient 2 tolerated the procedure.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 45201, issued to Doron Blumenfeld, M.D.;

2. Revoking, suspending or denying approval of Doron Blumenfeld, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Doron Blumenfeld, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring;

4. Ordering Respondent Doron Blumenfeld, M.D., if placed on probation, to provide patient notification in accordance with Business and Professions Code section 2228.1; and

5. Taking such other and further action as deemed necessary and proper.

DATED: AUG 30 2022

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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